Sutter Health

CALIFORNIA PACIFIC MEDICAL CENTER

2019 – 2021 Implementation Strategy Plan
Responding to the 2019 Community Health Needs Assessment

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Table of Contents

Introduction

The Implementation Strategy Plan describes how California Pacific Medical Center (CPMC), a Sutter Health affiliate, plans to address significant health needs identified in the 2019 Community Health Needs Assessment (CHNA). The document describes how the hospital plans to address identified needs in calendar (tax) years 2019 through 2021.

The 2019 CHNA and the 2019 – 2021 Implementation Strategy Plan were undertaken by the hospital to understand and address community health needs, and in accordance with state law and the Internal Revenue Service (IRS) regulations pursuant to the Patient Protection and Affordable Care Act of 2010.

The Implementation Strategy Plan addresses the significant community health needs described in the CHNA that the hospital plans to address in whole or in part. The hospital reserves the right to amend this Implementation Strategy Plan as circumstances warrant. For example, certain needs may become more pronounced and merit enhancements to the described strategic initiatives. Alternately, other organizations in the community may decide to address certain community health needs, and the hospital may amend its strategies and refocus on other identified significant health needs. Beyond the initiatives and programs described herein, the hospital is addressing some of these needs simply by providing healthcare to the community, regardless of ability to pay.

CPMC welcomes comments from the public on the 2019 Community Health Needs Assessment and 2019 – 2021 Implementation Strategy Plan. Written comments can be submitted:

- By emailing the Sutter Health System Office Community Benefit department at SHCB@sutterhealth.org;
- Through the mail using the hospital's address at P.O. Box 7999, San Francisco, CA 94120-7999, Attention: Community Benefit Department; and
- In-person at the hospital's Information Desk.

Executive Summary

CPMC is affiliated with Sutter Health, a not-for-profit public benefit corporation that is the parent of various entities responsible for operating healthcare facilities and programs in Northern California, including acute care hospitals, medical foundations and home health and hospice, and other continuing care operations. Together with aligned physicians, our employees and our volunteers, we're creating a more integrated, seamless and affordable approach to caring for patients.

The hospital's mission is to enhance the well-being of people in the communities we serve through a not-for-profit commitment to compassion and excellence in healthcare services.

Over the past five years, Sutter Health and its affiliates have committed nearly $4 billion to care for patients who couldn't afford to pay, and to support programs that improve community health. Our 2018 commitment of $734 million includes unreimbursed costs of providing care to Medi-Cal patients, traditional charity care and investments in health education and public benefit programs. For example:

- In 2018, Sutter invested $435 million more than the state paid to care for Medi-Cal patients. Medi-Cal accounted for nearly 19 percent of Sutter's gross patient service revenues in 2018.
- Throughout Sutter, we partner with and support community health centers to ensure that those in need have access to primary and specialty care. Sutter also supports children's health centers, food banks, youth education, job training programs, and services that provide counseling to domestic violence victims.

Every three years, Sutter Health affiliated hospitals participate in a comprehensive and collaborative Community Health Needs Assessment, which identifies significant community health needs and guides our community benefit strategies. The assessments help ensure that Sutter invests its community benefit dollars in a way that targets and addresses real community needs.

Through the 2019 Community Health Needs Assessment process, the following significant community health needs were identified:

- Access to coordinated, culturally and linguistically appropriate care and services
- Food security, healthy eating, and active living
- Housing security and an end to homelessness
- Safety from violence and trauma
- Social, emotional, and behavioral health

The 2019 Community Health Needs Assessment conducted by CPMC is publicly available at www.sutterhealth.org.

2019 Community Health Needs Assessment Summary

CPMC participates in a collective needs assessment process as a member of the San Francisco Health Improvement Partnership (SFHIP), a collaborative body whose mission is to embrace collective impact and to improve community health and wellness in San Francisco. Membership in SFHIP includes San Francisco Department of Public Health (SFDPH), San Francisco Mayor's Office, the city's nonprofit hospitals, and other healthcare-related nonprofit stakeholders.

SFHIP completes a CHNA once every three years, which provides data enabling identification of priority health issues and is the foundation for various citywide health planning processes, as well as each San Francisco nonprofit hospital's Community Health Needs Assessment and Implementation Strategy Plan.

The needs assessment for this report was conducted throughout 2017 and 2018. Meetings were facilitated by SFDPH, and the final CHNA document that was collectively developed by SFHIP was prepared by SFDPH.

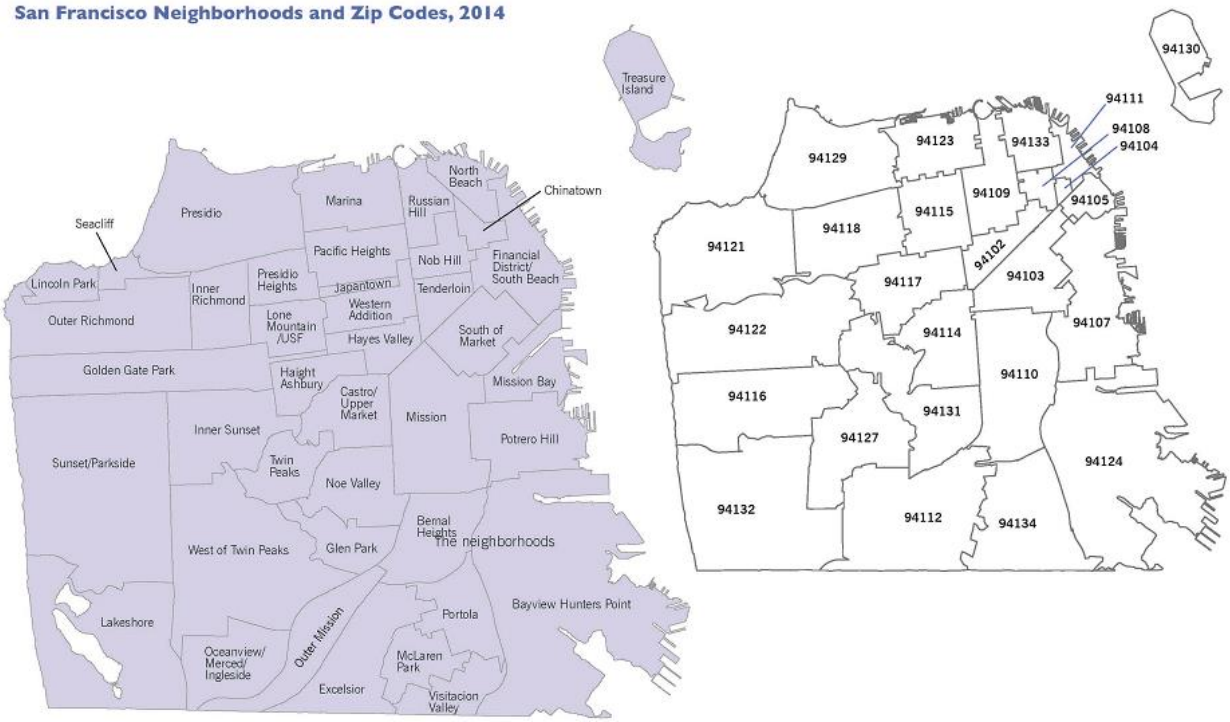
The CHNA process involved four steps:

1. **Community health status assessment**, in which 171 population-level health determinant and outcome variables were analyzed, ranked and selected, recognizing the essential role that social determinants of health play in the health of San Franciscans.
2. **Assessment of prior assessments**, in which a variety of health needs assessments already completed by various San Francisco community-based organizations, healthcare service providers, public agencies, and task forces were reviewed to ensure that this existing knowledge was integrated into the CHNA.
3. **Community engagement**, in which focus groups were conducted with various subject matter experts, community organizations, and community members. Categories of focus groups included:
    - SFHIP key informant group interview (comprised of SFHIP members);
    - Equity Coalition focus groups with Chicano/Latino/Indigena Health Equity Coalition, Asian and Pacific Islander Health Parity Coalition, and African American Community Health Equity Council;
    - Homeless Prenatal Program-led focus groups with food-insecure pregnant women; and
    - Kaiser-led focus groups with Kaiser Permanente leadership and staff, Spanish-speaking parents (on youth healthy eating and active living), and homeless and/or HIV-positive youth.
4. **Health needs identification and prioritization**, in which SFHIP members reviewed and screened all findings according to pre-established criteria in a multi-step process.

The full 2019 Community Health Needs Assessment conducted by CPMC is available at www.sutterhealth.org.

Definition of the Community Served by the Hospital

CPMC serves all populations residing in the City and County of San Francisco.



Ethnic composition by percentage of population, San Francisco, 2010–2030

Ethnicity	2010	2018	2030 Projected
White	42.3%	42.0%	42.5%
Black/African American	5.8%	5.0%	4.0%
Asian	33.1%	33.7%	34.0%
Pacific Islander	0.4%	0.4%	0.4%
Latino	15.1%	15.1%	14.9%
Native American	0.2%	0.2%	0.2%
Multi-ethnic	3.1%	3.6%	4.0%

Population by age group as a percentage of the total population projections, San Francisco, 2010–2030

Groups by age	2010	2018	2030 Projected
Seniors (65+)	14%	17%	21%
Working age (25-64)	63%	61%	56%
College age (18-24)	10%	7%	8%
School age (5-17)	9%	10%	11%
Preschool age (0-4)	4%	5%	4%

The CHNA reviewed health data on all San Francisco populations. Some important findings include:

- Total population (2018): 888,817
- Over 10,000 fewer San Franciscans were uninsured in 2017 compared to 2015. However, 2 percent (16,000) still lack insurance or healthcare access via Healthy San Francisco or Healthy Kids.
- 8 percent do not have a usual place to go for medical care.
- 24 percent of adults have not had a routine check-up in the past year.
- 51 percent have not had a flu shot in the past year.
- 54 percent of women ages 18 to 44 have not received counseling or information about birth control from a doctor or medical provider in the past year.

- 15 percent of women with public safety-net insurance do not receive timely prenatal care.
- 27 percent of adults have not seen a dentist in the past year.
- 96 percent of Whites are employed, while only 83 percent of Black/African Americans are employed.
- 22 percent of San Franciscans live below 200 percent of the federal poverty level.
- 1 percent of White children and 19 percent of Black/African American children live in poverty.
- San Francisco has the highest income inequality in California (and rates sixth in the U.S.); the wealthiest 5 percent of households earn 16 times more than the poorest 20 percent of households.
- 24 percent of San Francisco residents 5 years and older have limited English proficiency; 57 percent of those persons speak Chinese.

For further details regarding San Francisco's population, please refer to the full CHNA.

Significant Health Needs Identified in the 2019 CHNA

The following significant health needs were identified in the 2019 CHNA:

1. Access to coordinated, culturally and linguistically appropriate care and services
   San Francisco continued to see gains in access to healthcare, with 10,000 fewer residents uninsured in 2017 than in 2015. Of the estimated 31,500 uninsured residents, 15,373 have healthcare access through Healthy San Francisco or Healthy Kids. Approximately 2 percent of residents remain without access. Having insurance or an access program is only the first step, however; true access to services is influenced by location, affordability, hours of operation, and cultural and linguistic appropriateness of healthcare services.

2. Food security, healthy eating, and active living
   Inadequate nutrition and a lack of physical activity contribute to 9 of the leading 15 causes of premature death in San Francisco—heart failure, stroke, hypertension, diabetes, prostate cancer, colon cancer, Alzheimer's, breast cancer, and lung cancer. Studies have shown that just 2.5 hours of moderate-intensity physical activity each week is associated with a gain of approximately three years of life.

3. Housing security and an end to homelessness
   Housing is a key social determinant of health. Housing stability, quality, safety, and affordability all have very direct and significant impacts on individual and community health. Much of California, and especially the Bay Area, is currently experiencing an acute shortage in housing, leading to unaffordable housing costs, overcrowding, homelessness and other associated negative health impacts. Between 2011 and 2015, the Bay Area added 501,000 new jobs—but only 65,000 new homes. An estimated 24,000 people in San Francisco live in crowded conditions, and about 7,500 homeless persons were counted in San Francisco.

4. Safety from violence and trauma
   Violence not only leads to serious mental, physical and emotional injuries and, potentially, death for the victim, but also negatively impacts the family and friends of the victim and their community. Persons of color are more likely to be victims of violence, to live in neighborhoods not perceived to be safe, and to receive inequitable treatment through the criminal justice system.

5. Social, emotional, and behavioral health
   Mental health is an important part of community health. In San Francisco, the number of hospitalizations among adults due to major depression exceeds that of asthma or hypertension. Presence of mental illness can adversely impact the ability to perform across various facets of life—work, home, social settings. It also impacts the families, caregivers, and communities of those affected. Substance abuse of drugs, alcohol and tobacco contributes to 14 of the top causes of premature death in the city—lung cancer, chronic obstructive pulmonary disease, HIV,

drug overdose, assault, suicide, breast cancer, heart failure, stroke, hypertensive heart disease, colon cancer, liver cancer, prostate cancer, and Alzheimer's.

To identify and prioritize the most significant health needs in San Francisco, the SFHIP steering committee met on October 18, 2018. Participants identified health needs through a mult-step process. First, participants reviewed data and information from the Community Health Status Assessment, the Assessment of Prior Assessments, and the Community Engagement process, as well as the health priorities from the 2016 Community Health Needs Assessment. Then, using the Technology of Participation approach to consensus development, participants engaged in focused discussions about the data. Finally, participants developed consensus on the health needs by using the following steps:

1. Individually listing top health needs.
2. Small group discussions on the top health needs to identify similarities and differences.
3. Sharing all the health needs identified by the individuals.
4. Clustering the similar health needs into themes.
5. Determining a name for the theme, which is the health need.
6. Comparing and discussing new needs with those from the 2016 Community Health Needs Assessment.

Throughout the process, health needs were screened using the following pre-established criteria:

- The need is confirmed by more than one indicator and/or data source.
- The need performs poorly against a defined benchmark(s).

No further needs prioritization or ranking was deemed necessary since all five needs were considered to be very important.

2019 – 2021 Implementation Strategy Plan

The Implementation Strategy Plan describes how CPMC plans to address significant health needs identified in the 2019 Community Health Needs Assessment and is aligned with the hospital's charitable mission. The strategy describes:

- Actions the hospital intends to take, including programs and resources it plans to commit;
- Anticipated impacts of these actions and a plan to evaluate impact; and
- Any planned collaboration between the hospital and other organizations in the community to address the significant health needs identified in the 2019 CHNA.

Prioritized Significant Health Needs the Hospital Will Address

The Implementation Strategy Plan serves as a foundation for further alignment and connection of other CPMC initiatives that may not be described herein, but which together advance the hospital's commitment to improving the health of the communities it serves. Each year, programs are evaluated for effectiveness, the need for continuation, discontinuation, or the need for enhancement. Depending on these variables, programs may change to continue focus on the health needs listed below (alphabetically).

1. Access to coordinated, culturally and linguistically appropriate care and services
2. Food security, healthy eating, and active living
3. Housing security and an end to homelessness
4. Safety from violence and trauma
5. Social, emotional, and behavioral health

Access to Coordinated, Culturally and Linguistically Appropriate Care and Services

Name of program/activity/initiative	St. Luke's Health Care Center (SLHCC) & HealthFirst
Description	CPMC's SLHCC provides a full range of obstetric and gynecological care at its Women's Center; well-baby care, well-child care, and care for ill or injured children at its Pediatric Clinic; and primary, acute and chronic care at its Adult Internal Medicine Clinic for teenagers and adults. SLHCC's clinicians and staff are bilingual in English and Spanish, ensuring culturally and linguistically competent care. Without SLHCC, many of these patients would have to use services at San Francisco General Hospital and its public clinics, facilities that are operating at full capacity. SLHCC's services also counter limited access that may be caused by primary care providers being less likely to serve Medi-Cal beneficiaries due to low government reimbursement rates. HealthFirst, a center for health education and disease prevention affiliated with SLHCC, serves patients in chronic disease management by integrating community health workers (CHWs) into the multidisciplinary healthcare team. CHWs are culturally and linguistically competent as they are recruited from the same community as the patients that HealthFirst serves. CHWs provide health education, assist patients to improve their self-management skills, and encourage them to receive timely and comprehensive care.
Goals	Expand the city's safety net and bridge gaps in accessibility by making services more readily available to publicly insured and uninsured populations, and making those services culturally and linguistically appropriate. Manage chronic illness with cost-effective, quality care by providing prevention, outreach, and education services in a primary care setting that is culturally and linguistically appropriate for uninsured and underinsured patients residing in communities south of Market Street in San Francisco.
Anticipated Outcomes	Increase culturally and linguistically appropriate healthcare services for uninsured and underinsured patients residing in communities south of Market Street in San Francisco—some of the neighborhoods identified as having the highest disparities related to important socio-economic determinants of health.
Metrics Used to Evaluate the program/activity/initiative	Number of persons served (including demographic data) Number of encounters Number of HealthFirst's health screenings (spirometry tests, eye exams, foot exams, albumin/creatinine ratio tests)

Name of program/activity/initiative	Healthcare Coverage Enrollment Assistance
Description	Program staff assist eligible CPMC patients and their families to enroll in assistance programs such as Medi-Cal, Healthy Families, and county programs.
Goals	Make healthcare services more readily available to previously uninsured populations and reduce the financial burden of medical bills.
Anticipated Outcomes	Increased access to more timely, high-quality preventive care, primary care, and specialty care services.
Metrics Used to Evaluate the program/activity/initiative	Number of persons enrolled in assistance programs

Name of program/activity/initiative	Kalmanovitz Child Development Center (KCDC)
Description	CPMC's Kalmanovitz Child Development Center provides diagnosis, evaluation, treatment and counseling for children and adolescents with learning disabilities and developmental or behavioral problems caused by prematurity, autism spectrum disorder, epilepsy, Down syndrome, attention deficit disorder, or cerebral palsy. Its comprehensive assessments and ongoing therapy programs include the following disciplines: Developmental/Behavioral Pediatrics; Psychology and Psychiatry; Speech/Language and Auditory Processing; Occupational Therapy; Behavior Management Consultations; Early Intervention/Parent-Infant Program; Social Skills Groups; Feeding Assessment and Therapy; Assessment and Therapy for the Neonatal Intensive Care Unit and Assessment for the Follow-Up Clinic; Educational Assessment, Therapy and Treatment. These services provided at reduced or no cost to families are particularly important since children from low-income families have a 50 percent higher risk of developmental disabilities; early identification and treatment can change the course of these children's lives. Besides operating its own clinics, KCDC also extends its services to a large number of at-risk children and brings services to them in their community by partnering with local schools and other community organizations, such as De Marillac Academy and Sacred Heart Cathedral Preparatory. De Marillac Academy is a tuition-free independent Catholic school serving low-income fourth-to-eighth-grade students in San Francisco's Tenderloin District, where many children suffer from post-traumatic stress disorder impacting their ability to learn. In a unique program that goes beyond the daily classroom setting, clinical and family support services are provided by KCDC to help children process those experiences and overcome the emotional challenges that often accompany them. Speech and language pathologists, educational therapists, and clinical psychologists provide more intensive services as needed at the school; occupational therapy is done at KCDC locations.
Goals	Help children and youth in San Francisco to thrive and live up to their full potential by providing early multidisciplinary assessment and treatment for children with one or more conditions that affect their growth and development, regardless of the patient's ability to pay.
Anticipated Outcomes	Increase services for children with one or more conditions that affect their growth and development.
Metrics Used to Evaluate the program/activity/initiative	Number of persons served at San Francisco clinic locations and through outreach at De Marillac Academy Number of encounters

Name of program/activity/initiative	South of Market Bayview Child Health Center (BCHC)
Description	BCHC offers routine preventative and urgent pediatric care in one of San Francisco's most medically underserved neighborhoods, and addresses prevalent community health issues such as weight control and asthma management. BCHC focuses on keeping infants, children and adolescents healthy, and on closely managing their care when they are ill. The center is particularly attuned to the impact of community violence and childhood trauma on children's mental and physical health. The clinic also offers psychological and case management services to families through a partnership with the Center for Youth Wellness. Dental services are provided through South of Market Health Center at their main facility. The clinic was started as a collaboration between CPMC, Sutter Pacific Medical Foundation, and CPMC Foundation. In 2014, clinic ownership was transferred to South of Market Health Center (SMHC), and we were jointly awarded a grant to transition BCHC to become a Federally Qualified Health Center. CPMC continues to be the hospital and specialty partner for BCHC and continues to help fund operational costs. CPMC and SMHC will work together to ensure that kids in the Bayview have access to high-quality care while ensuring the clinic's long-term sustainability.
Goals	Improve access to high-quality healthcare close to home for uninsured and underinsured children residing in the Bayview Hunters Point district of San Francisco, regardless of ability to pay.
Anticipated Outcomes	Increase pediatric care, psychological, and case management services to children and families of Bayview Hunters Point.
Metrics Used to Evaluate the program/activity/initiative	Number of persons served Number of encounters Number of persons connected to a PCP Number of persons connected to mental health services

Name of program/activity/initiative	Coming Home Hospice
Description	CPMC's Coming Home Hospice provides 24-hour care for terminally ill clients and their families in a caring, homelike setting. CPMC ensures that high-quality residential hospice care is accessible to terminally ill patients regardless of their ability to pay, by covering the difference between the full cost of providing these services and patient revenue. Services include medical and nursing care, psycho-social counseling, spiritual counseling, religious services, massage therapy, medication monitoring and assistance, personal care assistance, laundry services, recreational activities and entertainment.
Goals	Increase access to quality hospice care and support for those for whom home is no longer an option, regardless of ability to pay.
Anticipated Outcomes	Increase quality hospice care services and support.
Metrics Used to Evaluate the program/activity/initiative	Number of persons served (including demographic data)

Name of program/activity/initiative	African American & Sister to Sister Breast Health Program and Mission Bernal Campus Breast Health Partnerships
Description	CPMC's African American & Sister to Sister Breast Health Program offers women mammography screening and all the subsequent breast health diagnostic testing and treatment they may need at no cost. Early detection allows for better treatment outcomes and longevity of life. Partnership organizations such as HealthRIGHT 360, San Francisco Free Clinic, and Clinic by the Bay refer uninsured, underinsured, disadvantaged and at-risk women for mammography services. CPMC's Breast Center at the Mission Bernal Campus promotes breast health in underserved communities by partnering with neighborhood clinics and community agencies.
Goals	Increase early breast cancer detection by providing access to no-cost mammography screening for uninsured women who live in San Francisco. Reduce barriers to quality care.
Anticipated Outcomes	Increase early mammography screenings for women in need. Women who face particular challenges in completing treatment will receive assistance with care navigation services.
Metrics Used to Evaluate the program/activity/initiative	Number of persons served Number of screenings/mammograms Number of persons who received care navigation services Number of persons who received follow-up clinical care

Name of program/activity/initiative	Operation Access
Description	CPMC partners with Operation Access and San Francisco Endoscopy Center to provide access to diagnostic screenings, specialty procedures, and surgical care at no cost for uninsured Bay Area patients who have limited financial resources. CPMC physicians volunteer their time to provide these free surgical services, while the hospital donates the use of its operating rooms. CPMC also provides grant funding to support Operation Access's operating costs.
Goals	Increase healthcare equity for uninsured and underserved patients facing barriers to getting the outpatient surgical and specialty care that they need, by: • Providing the resources and promoting the medical volunteerism needed for the donation of these services; • Increasing culturally competent case management; • Providing medical interpreters to facilitate donated care.
Anticipated Outcomes	Increase number of timely surgical procedures and diagnostic services provided to uninsured and underserved patients.
Metrics Used to Evaluate the program/activity/initiative	Number of persons served Number of operating room procedures provided Number of GI procedures provided Number of minor and radiology procedures provided Number of specialist evaluations Number of CPMC medical volunteers Client compliance rate Median wait time from referral to specialty visit Patient satisfaction rate

Name of program/activity/initiative	Lions Eye Foundation
Description	Lions Eye Foundation and CPMC partner together to provide highly specialized eye care procedures free of charge to people without insurance or financial resources.
Goals	Provide access to highly specialized eye care for people without insurance or financial resources.
Anticipated Outcomes	Increase eye care procedures/services for uninsured, low-income patients residing in San Francisco.
Metrics Used to Evaluate the program/activity/initiative	Number of persons served Number of encounters Number of general surgical procedures Number of laser surgeries Number of intravitreous injections for macular degeneration and eye complications due to diabetes Number of diagnostic tests (OCTs, B-scans, angiograms, etc.)

Name of program/activity/initiative	Advanced Illness Management (AIM) Program
Description	Sutter Health's Advanced Illness Management (AIM) program provides customized support for patients with advanced chronic illnesses in order to improve care transitions and reduce future hospitalization. It helps them to manage their health/illness symptoms, manage their medications, coordinate their care, plan for the future, and live the kind of life they want. CPMC supports the program, providing funding towards the care of the people who enroll in the program in the San Francisco service area. Once the AIM team understands the patient's health issues, lifestyle, and personal preferences, they work with the patient to tailor a care plan, ease the transition from hospital to home, and provide continuing over-the-phone support and in-person visits in the home or at the doctor's office as needed. If the patient returns to the hospital, AIM staff continues to support the patient there. The AIM team also provides support for the patient's family and helps them understand anything about the patient's condition that the patient wants them to know.
Goals	Help chronically ill patients better manage their health/illness through skilled, respectful coaching and care tailored to their needs.
Anticipated Outcomes	Increase coaching services and support for patients who need help in self-managing advanced chronic illness.
Metrics Used to Evaluate the program/activity/initiative	Number of persons enrolled in the program's San Francisco service area (including demographic data as available) Number of persons transitioned to home/self-care from hospital Number of persons transitioned to home healthcare service

Name of program/activity/initiative	Medi-Cal Managed Care Partnerships
Description	A key part of CPMC's Medi-Cal program is the Medi-Cal Managed Care partnership with North East Medical Services (NEMS) community clinics and San Francisco Health Plan (SFHP), a licensed community health plan that provides affordable healthcare coverage to over 145,000 low- and moderate-income San Francisco residents. Working together with NEMS, CPMC serves as the hospital partner for these Medi-Cal beneficiaries who select NEMS as their medical group through San Francisco Health Plan, providing them with inpatient services, hospital-based specialty and ancillary services, and emergency care. CPMC also provides access to quality services at its Mission Bernal Campus for patients who select Hill Physicians or Brown & Toland as their medical group through San Francisco Health Plan. Additionally, CPMC provides lab services free of charge for NEMS patients in order to further improve access and support NEMS and their patients.
Goals	Improve access to quality services for publicly insured people in San Francisco.
Anticipated Outcomes	More Medi-Cal patients residing in San Francisco will receive timely, high-quality healthcare services.
Metrics Used to Evaluate the program/activity/initiative	Number of persons enrolled in the program (including demographic data as available) Bed days per 1,000 ER visits per 1,000

Name of program/activity/initiative	Grants and Sponsorships Addressing Access t**o** Coordinated, Culturally and Linguistically Appropriate Care and Services
Description	Grants and sponsorships are decided annually based on community need. Selected executed grants and sponsorships will be reported at year end.
Goals	Expand the city's safety net by making healthcare services more readily available to publicly insured and uninsured populations, and making those services culturally and linguistically appropriate.
Anticipated Outcomes	Increase affordable, accessible, culturally and linguistically appropriate healthcare services for uninsured and underinsured patients by supporting community-based organizations that develop/expand clinical services, outreach programs, and health education workshops to ensure that the needs of underserved populations are met.
Metrics Used to Evaluate the program/activity/initiative	Possible metrics include: Number of persons served (including demographic data if available/applicable) Number of classes/workshops offered Number of health screenings and other services provided

Food Security, Healthy Eating, and Active Living

Name of program/activity/initiative	HealthFirst
Description	HealthFirst, a center for health education and disease prevention affiliated with CPMC's St. Luke's Health Care Center, serves patients in chronic disease management by integrating community health workers (CHWs) into the multidisciplinary healthcare team. CHWs are culturally and linguistically competent as they are recruited from the same community as the patients that HealthFirst serves. CHWs provide health education, assist patients to improve their self-management skills, and encourage them to receive timely and comprehensive care. CHWs teach community workshops in healthy eating to parents of children at risk for obesity in the South of Market, Mission, and Bayview Hunters Point districts. They also teach classes on nutrition designed to manage chronic adult diabetes.
Goals	Manage chronic illness with cost-effective, quality care by providing prevention, outreach, and education services in a primary care setting that is culturally and linguistically appropriate for uninsured and underinsured patients residing in communities south of Market Street in San Francisco.
Anticipated Outcomes	Improve patients' self-management skills through culturally and linguistically appropriate services and health education.
Metrics Used to Evaluate the program/activity/initiative	Number of persons served (including demographic data) Number of encounters Number of health screenings (spirometry tests, eye exams, foot exams, albumin/creatinine ratio tests) Percentage of patients under control for hemoglobin HbA1c (diabetic), blood pressure, asthma, LDL cholesterol (as available)

Name of program/activity/initiative	Grant to Meals on Wheels
Description	Meals on Wheels San Francisco (MOWSF) helps low-income, homebound seniors to age safely at home by providing nourishing meals, safety support, and interpersonal and community connections. MOWSF currently provides 83 percent of home-delivered meals in San Francisco, but its current facility cannot keep pace with demand as the city's senior population grows. The CPMC grant supports the organization to build and equip a 45,000 square foot meal production facility that will include a full-capacity, commercial kitchen for food preparation, storage, access space and distribution yard.
Goals	Disrupt a system of hidden senior hunger, poverty and isolation. Provide the San Francisco community with a substantially enhanced safety net by providing low-income, isolated, homebound seniors with two nutritious meals per day, social work assistance and an array of support services allowing them to prosper in their homes.
Anticipated Outcomes	Efficiently increase meal production capacity. Enhance ability to prepare medically tailored meals and offer culturally appropriate meal options, including plant-based menus.
Metrics Used to Evaluate the program/activity/initiative	Number of persons served Number of meals provided/delivered

Name of program/activity/initiative	Grant to Community Health Resource Center (CHRC)
Description	CHRC collaborates with over 20 different healthcare centers in San Francisco, providing supportive services to thousands of clients through the many free or low-cost programs, screenings and counseling services that are available to anyone in the community. Programs include dietitians, social work counseling, nutrition guidance, community health screenings, educational lectures including monthly wellness events, health information and local resources, employee and group wellness presentations, and support groups. Services are offered free, at a reduced cost, or on a sliding scale. In CHRC's Nutrition Counseling program, the team of highly qualified registered dietitians is available by appointment for nutrition counseling and diet review, with the goal of establishing a diet balanced for all life stages. Nutritionists are cross-trained to meet the nutritional needs and provide guidance for a variety of conditions, concerns and goals. Dietitians are also trained to address weight management concerns specific to age through a number of healthy, supportive treatment options. Dieticians also bring their knowledge to the community by presenting to a variety of community groups.
Goals	Increase knowledge and awareness regarding healthy eating and help patients to effectively meet their goals as they relate to nutrition and diet.
Anticipated Outcomes	Increase high-quality, professional supportive services, tools and information for healthy eating among San Francisco residents.
Metrics Used to Evaluate the program/activity/initiative	Number of appointments with a registered dietitian Number of health screenings related to diet/exercise (BMI, glucose, etc.) Number of health education presentations/classes related to nutrition/ exercise, with number of attendees

Name of program/activity/initiative	Grants and Sponsorships Addressing Food Security, Healthy Eating, and Active Living
Description	Grants and sponsorships are decided annually based on community need. Selected executed grants and sponsorships will be reported at year end.
Goals	Enhance health and well-being by providing nutritious meals, groceries, and/or food choices to those in need. Facilitate behavioral changes of adults and children in homes, schools, worksites, and communities that will lead to the consumption of healthier foods and increased physical activity. Identify and respond to risk factors such as obesity and inactivity that have been linked to cardiovascular disease, stroke, diabetes, gallbladder disease, osteoarthritis, and certain cancers. Establish a culture of health consciousness among adults and children.
Anticipated Outcomes	Examples: • Increase knowledge and awareness regarding healthy eating and physical activity among adults and children through culturally relevant tools and information. • Increase children's and adults' access to healthy and nutritious foods. • Increase children's and adults' participation in various forms of exercise through exercise and fitness programs.

	• Increase referral and case management for children who are at risk of poor nutrition, obesity, and obesity-related diseases.
Metrics Used to Evaluate the program/activity/initiative	Possible metrics include: Number of persons served (including demographics if available/applicable) Number of meals provided Number of classes/workshops offered Number of health screenings provided

Housing Security and an End to Homelessness

Name of program/activity/initiative	Grant to Compass Family Services
Description	Compass Family Services operates programs that provide year-round services to homeless families and families at imminent risk for homelessness. Programs include: • Compass Connecting Point, a Family Resource Center: centralized drop-in center with childcare providing assessment, shelter placement, counseling, and referral services for families facing a housing crisis. • Compass Family Shelter: emergency shelter, with on-site supportive services and long-term follow-up care. • Compass Clara House: 18-month transitional housing with comprehensive supportive services for homeless families. • Compass Children's Center: nationally accredited early childhood education and childcare center for homeless and extremely low-income infants and toddlers. • Compass SF HOME: intensive support services combined with rent subsidies to help families avert homelessness. • Compass Clinical Services: critical mental health services to clients. • Twitter NeighborNest: state-of-the-art technology lab with on-site childcare to help families bridge the technological divide. • OneHome: free affordable housing search website that makes it easier to find and apply for available housing.
Goals	Assist families in securing and maintaining permanent housing. Help families address barriers to economic self-sufficiency. Support the healthy development of children and families. Address mental health and substance abuse problems.
Anticipated Outcomes	• Help homeless or at-risk families achieve housing stability, economic self-sufficiency, and well-being; 90 percent of families remain stably housed after 12 months. • Provide homeless or at-risk children with full-time infant and toddler care and pre-school, with achievement of age-appropriate skills upon graduation from the program and readiness to enter kindergarten. • Provide mental health services to children or parents, with demonstrable improvement in the overall functioning and mental health of participating individuals.
Metrics Used to Evaluate the program/activity/initiative	Number of persons housed in homeless shelter, number of shelter nights provided Number of persons connected to permanent or transitional housing Number of persons/families served with comprehensive support services

Name of program/activity/initiative	Grants and Sponsorships Addressing Housing Security and an End to Homelessness
Description	Grants and sponsorships are decided annually based on community need. Selected executed grants and sponsorships will be reported at year end.
Goals	End homelessness. Stabilize individuals and families at risk for homelessness.
Anticipated Outcomes	Examples: • Provide transitional/permanent housing and additional resources to address the causes of homelessness. • Provide comprehensive supportive services to individuals and families who are homeless or at risk for homelessness to stabilize their housing status. • Increase availability and/or accessibility of safe, affordable housing.
Metrics Used to Evaluate the program/activity/initiative	Possible metrics include: Shelter nights provided Number of persons provided with temporary housing Number of persons connected to permanent housing Number of persons/families served with comprehensive support services

Safety from Violence and Trauma

Name of program/activity/initiative	Grants and Sponsorships Addressing Safety from Violence and Trauma
Description	Grants and sponsorships are decided annually based on community need. Selected executed grants and sponsorships will be reported at year end.
Goals	Ensure that every child and adult is protected and our community is safe from child abuse and other forms of violence; prevent child abuse and domestic violence and reduce their devastating impact through supportive services, education, and policy advocacy.
Anticipated Outcomes	Examples: • Increase high-quality services for victims of child abuse and domestic violence. • Increase student/caregiver/community education programs on child abuse and how to prevent it. • Increase support services to at-risk parents, families, and individuals.
Metrics Used to Evaluate the program/activity/initiative	Possible metrics include: Number of persons connected to social services Number of persons connected to mental health services Number of persons connected to substance abuse treatment services Number of persons case-managed Number of parent education classes/participants Number of students educated in child safety awareness classes

Social, Emotional, and Behavioral Health

Name of program/activity/initiative	Kalmanovitz Child Development Center (KCDC)
Description	CPMC's Kalmanovitz Child Development Center provides diagnosis, evaluation, treatment and counseling for children and adolescents with learning disabilities and developmental or behavioral problems caused by prematurity, autism spectrum disorder, epilepsy, Down syndrome, attention deficit disorder, or cerebral palsy. Its comprehensive assessments and ongoing therapy programs include the following disciplines: Developmental/Behavioral Pediatrics; Psychology and Psychiatry; Speech/Language and Auditory Processing; Occupational Therapy; Behavior Management Consultations; Early Intervention/Parent-Infant Program; Social Skills Groups; Feeding Assessment and Therapy; Assessment and Therapy for the Neonatal Intensive Care Unit and Assessment for the Follow-Up Clinic; Educational Assessment, Therapy and Treatment. These services provided at reduced or no cost to families are particularly important since children from low-income families have a 50 percent higher risk of developmental disabilities; early identification and treatment can change the course of these children's lives. Besides operating its own clinics, KCDC also extends its services to a large number of at-risk children and brings services to them in their community by partnering with local schools and other community organizations, such as De Marillac Academy and Sacred Heart Cathedral Preparatory. De Marillac Academy is a tuition-free independent Catholic school serving low-income fourth-to-eighth-grade students in San Francisco's Tenderloin District, where many children suffer from post-traumatic stress disorder impacting their ability to learn. In a unique program that goes beyond the daily classroom setting, clinical and family support services are provided by KCDC to help children process those experiences and overcome the emotional challenges that often accompany them. Speech and language pathologists, educational therapists, and clinical psychologists provide more intensive services as needed at the school; occupational therapy is done at KCDC locations.
Goals	Help children and youth in San Francisco to thrive and live up to their full potential by providing early multidisciplinary assessment and treatment for children with one or more conditions that affect their growth and development, regardless of the patient's ability to pay.
Anticipated Outcomes	Increase services for children with one or more conditions that affect their growth and development.
Metrics Used to Evaluate the program/activity/initiative	Number of persons served at San Francisco clinic locations and through outreach at De Marillac Academy Number of encounters

Name of program/activity/initiative	Grant to Community Health Resource Center
Description	CHRC collaborates with over 20 different health care centers in San Francisco, providing supportive services to thousands of clients through the many free or low-cost programs, screenings and counseling services that are available to anyone in the community. Programs include dietitians, social work counseling, nutrition guidance, community health screenings, educational lectures including monthly wellness events, health information and local resources, employee and group

	wellness presentations, and support groups. Services are offered free, at a reduced cost, or on a sliding scale. CHRC's Behavioral/Mental Health Services by a licensed team of professionals offer support to individuals, groups and families looking for emotional or practical guidance and support for a wide range of needs. Fees for services are on a sliding scale. Counseling sessions may include: Individualized Needs Assessment to help clarify and prioritize the patient's most urgent concerns in order to develop goals and identify possible solutions; Short-term Emotional Support where counselors help align resources and make recommendations; Resource and Referral where a social worker can help connect the patient with other resources and agencies such as insurance, housing, reduced billing options for utilities, transportation, as well as a wide range of specific community support; Psychotherapy based on individual needs; and Follow-up Support. Examples of support groups/programs include the Cancer Buddy Program that connects recently diagnosed cancer patients with trained volunteer cancer survivors; the Stroke Survivor Support Group designed to aid the recovery of stroke survivors at any stage by providing a safe and supportive atmosphere where individuals are able to share their experiences; and the Liver Cancer Support Group, where those living with liver cancer, family members, loved ones, and caregivers are provided with emotional and social support, education, and shared experience in an open, accepting environment. Educational classes offered by the CHRC social workers include topics such as advanced health care directives, bereavement, care for givers, and dementia.
Goals	Improve the mental health and well-being of San Francisco residents.
Anticipated Outcomes	Increase behavioral/mental health services and connectivity to needed social services for San Francisco residents.
Metrics Used to Evaluate the program/activity/initiative	Number of appointments for behavioral health/social work services Number of support group attendees Number of health education presentations/classes related to behavioral health, with number of attendees

Name of program/activity/initiative	Psychiatry Residents Serving at Community-Based Organizations
Description	As part of CPMC's health professions education program, CPMC psychiatry residents provide services one day per week to patients in need of behavioral health services at community-based organizations and public institutions. These organizations provide treatment for substance use disorder and other mental health problems, geriatric psychiatric services, and/or social support and re-entry services for incarcerated/formerly incarcerated clients to help them to attain self-sufficiency and continued recovery.
Goals	Improve the mental health and well-being of at-risk populations by making high-quality services more readily available.
Anticipated Outcomes	Increase mental health and substance abuse services for at-risk populations.
Metrics Used to Evaluate the program/activity/initiative	Number of persons served through the residents' time spent at each of the community/public organizations

Name of program/activity/initiative	Grants and Sponsorships Addressing Social, Emotional, and Behavioral Health
Description	Grants and sponsorships are decided annually based on community need. Selected executed grants and sponsorships will be reported at year end.
Goals	Promote mental health and the healthy development of children and families in both the broader community and at-risk communities; prevent child abuse and domestic violence.
Anticipated Outcomes	Examples: • Increase re-entry social support services that empower formerly incarcerated residents to attain economic self-sufficiency, continued recovery, and creation of a stable living environment by building skills, accessing resources, and modeling professional behavior. • Increase substance use disorder treatment services that are gender-responsive and welcoming to people of any gender identity. • Increase support to families in need of resources, such as employment training, parent education classes, housing, child care, and shelters. • Increase intensive assessment, counseling, and referral services to help families and individuals avert homelessness. • Increase mental health services to homeless and at-risk youth. • Increase linguistically and culturally appropriate support groups and counseling. • Increase early childhood education for at-risk families. • Increase integrated treatment services for clients with co-occurring substance use disorder and mental health problems. • Increase integration of behavioral health services into existing primary care settings for at-risk San Francisco residents.
Metrics Used to Evaluate the program/activity/initiative	Possible metrics include: Number of persons served (including demographics as available) Number of encounters Number of persons connected to mental health services or social services

Name of program/activity/initiative	Psychiatry Residency & Psychology Intern Training Program
Description	As a multi-campus teaching hospital, CPMC offers educational experience to physicians through its residency training programs, which include Psychiatry. Psychology interns and fellows also receive training while working in locations such as Kalmanovitz Child Development Center, Adult In-Patient, and Women's Health Initiative. CPMC usually trains 16 psychiatric residents, 10 psychology interns, and 2 psychology fellows annually.
Goals	The next generation of mental/behavioral healthcare professionals will receive world-class training/educational experience.
Anticipated Outcomes	Increase number of well-trained psychiatrists and psychologists and the availability of these services in the future.
Metrics Used to Evaluate the program/activity/initiative	Number of psychiatry residents and psychology interns and fellows trained

Needs CPMC Plans Not to Address

Although no hospital can address all aspects of the health needs present in its community, CPMC plans to address all five of the significant health needs identified in the 2019 Community Health Needs Assessment. As a member of SFHIP, CPMC will continue to work in collaboration with other local hospitals and health plans to identify gaps in service and to determine where efforts should be collectively redirected in order to most effectively improve the health of San Francisco residents. For more information about SFHIP, please visit www.sfhip.org.

CPMC is committed to serving the community by adhering to its mission, using its skills and capabilities, and remaining a strong organization so that it can continue to provide a wide range of community benefits.

Approval by Governing Board

The Community Health Needs Assessment and Implementation Strategy Plan were approved by the Sutter Bay Hospitals Board of Directors on November 20, 2019.